MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Integrating Employment Support with Primary Healthcare Services

A Review of Models and Evidence

May 2023

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Acknowledgements

The authors are grateful to Dr Clare Dominick (MSD), Moira Wilson (MSD), Dr Stephanie Palmer (MSD), Diane Anderson (MSD), Amanda Mainey (MSD), Telsa Edge (MSD), Celeste Daymond (MSD), and the Strategy and Insights Feedback Clinic Team (MSD) for their helpful comments, review, and advice.

Disclaimer

The views and interpretations in this report are those of the Research and Evaluation team and are not the official position of the Ministry of Social Development.

Published

Ministry of Social Development
PO Box 1556
Wellington
www.msd.govt.nz/insights

April 2023

ISBN

978-1-99-110511-0

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Executive Summary

This document presents findings from a review of programmes that integrate employment support with primary healthcare for disabled people and people with health conditions. Evidence on these programmes can inform decisions about the Oranga Mahi programme and support the development of initiatives to support people with disabilities and health conditions, such as those included in the Active Labour Market Policy (ALMP) review and the proposed Income Insurance Scheme.

Main findings

The review found that integration of employment support and healthcare services can help lessen barriers for disabled people and people with health conditions entering and remaining in employment. Combining work-focused strategies with clinical care is more effective than using either strategy alone.

The provision of successfully integrated person-centred care can improve the availability, quality, and efficiency of services, particularly for people with complex health needs, however, it can be challenging to integrate services well. A successful integrated approach is likely to have multiple requirements at all levels to establish structures, mechanisms and processes that support integration, and to build a collaborative culture.

Overall, review findings suggest that multi-component programmes to integrate primary healthcare and employment support, such as IPS, have the greatest likelihood of improving management of health conditions and helping people into sustainable employment. However, more investigation of other approaches is needed in the New Zealand context, and it is vital to investigate more fully how these programmes work for Māori and Pacific Peoples.

Programmes that have used a patient navigation model of integration, or a co-location model other than IPS, have received limited investigation but results look promising. Available findings suggest that further evaluation of these programmes is warranted.

Recommendations for designing and implementing integrated programmes

Based on the review findings, we recommend the following are taken into consideration when designing and implementing integrated programmes in New Zealand:

- Multi-component programmes that involve employment specialists co-located within health services, such as IPS, have the strongest evidence base and the greatest likelihood of improving management of health conditions and helping people into sustainable employment. These programmes provide a comprehensive package of services and include engagement with prospective employers.

- More research investigating multi-component programmes, such as IPS, in New Zealand primary care services is recommended, particularly, work is needed to understand how employment outcomes vary by ethnicity in response to IPS, and to ensure that programmes are designed and delivered in a way that supports the

employment aspirations of Māori.

- More investigation of other integration approaches is needed in the New Zealand context, to understand how these programmes work for Māori and Pacific Peoples. It is essential to understand how different integration approaches are experienced by Māori, and for Kaupapa Māori programmes to be developed.

- Successful programmes take a person-centred approach and are characterised by effective communication and coordination between health professionals, employment specialists, and employers.

- Programmes should recognise how health conditions and/or disabilities affect the capacity of people to engage with employment-focused activities, including when they have moved into work, and ensure that support for people to manage their health is available. Programmes that provide limited support from health professionals tend to have low levels of retention and engagement.

- Adequate communication and reporting systems are needed to ensure that programme delivery and outcomes can be consistently monitored over time. This data is critical for evaluating the success of a programme, and for informing any changes to design and implementation.

- It is important that programmes endeavour to achieve outcomes associated with sustainable employment, such as engagement in part-time work and health and wellbeing, rather than focusing solely on off-benefit employment outcomes.

- Outcomes need to be monitored over sufficiently long periods to detect clinically meaningful changes in outcomes over time.

Limitations

No strong evidence for case management approaches to integration were found internationally, and variable results have been found in New Zealand. However, an evaluation of a Kaupapa Māori case management programme reported high participant engagement and improvements in physical and mental wellbeing.

There is not enough information about how different integration approaches are experienced by Māori to make any comment on their success or suitability for Māori. Only one Kaupapa Māori programme was identified in the literature search. Furthermore, only two evaluations provided information on how programmes were experienced by Māori and no evaluations reported experiences of other Indigenous people. A review of general Indigenous employment programs implemented in Australia noted that programmes delivered by Indigenous people are more effective, reflecting their ability to provide support in a culturally appropriate way.

Introduction

This review provides an overview of existing evidence on integrated programmes like Oranga Mahi. It is based on evaluations of programmes that are designed to integrate employment support with primary healthcare for disabled people and people with health conditions. The review includes 15 evaluations of 12 unique programmes delivered in NZ, and 21 evaluations of 17 unique international programmes. Detailed information on the methodology can be found in Appendix One.

The review provides information and evidence that can be used to guide decision-making in relation to the Oranga Mahi programme[1], including decisions about potential modifications and/or expansions. Specific objectives of the review were:

- To identify the range of models underpinning programmes that integrate employment support with primary healthcare for disabled people and people with health conditions.
- To describe the specific programmes that have been investigated and provide detail on:
    - the implementation of programmes, including factors that help and hinder implementation
    - the effectiveness of programmes with respect to modifying outcomes, including employment, health, and wellbeing outcomes.

Background

Understanding Health and Disability

Health and disability are evolving concepts. Organisations within the disability sector generally ascribe to a biopsychosocial model of disability which describes disabled people as including those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UNCRPD, 2006).

Likewise, health, once thought of solely as the absence of disease or disorder, is now usually viewed as a multidimensional concept that takes a person's physical, intellectual, emotional, social, and spiritual states into account. There is no sole determinant of individual wellbeing, but general wellbeing is dependent upon good health, positive social relationships and the availability of and access to basic resources (e.g., shelter, income) (WEAG, 2019).

[1] The Oranga Mahi programme includes several initiatives funded by the Ministry of Social Development (MSD) and co-designed in partnership with health sector providers. The initiatives support disabled people and people with health conditions, who are currently MSD clients or are at risk of becoming MSD clients, to improve their health, wellbeing, and employment outcomes. A key feature of the Oranga Mahi programme is the integration of employment support and primary healthcare.

Difficulties engaging in stable and secure work are likely to be experienced by an increasing number of people over time. Factors such as, aging populations, increases in chronic health conditions, and poverty, among other causes, mean the prevalence of people living with health conditions is increasing globally, in addition to the proportion of people managing multiple health conditions (Esteban et al., 2018).

Suitable paid employment has health benefits for disabled people and people with health conditions

The health promoting effects of work have been well-documented among disabled people and people with health conditions (Leonardi & Scaratti, 2018). Remaining in or re-entering the workforce is associated with better health outcomes, reduced risk of long-term incapacity, increased independence, and improved quality of life and wellbeing (Waddell & Burton, 2006). People with disabling conditions also report that work generates feelings of normality and provides opportunities for socialisation (Saunders & Nedelec, 2014). There is strong evidence that participation in suitable paid employment is beneficial for health and wellbeing (Waddell & Burton, 2006). That said, some physical and psychosocial aspects of work can also pose risks to health (Waddell & Burton, 2006).

Disabled people and people with health conditions have lower rates of employment and are more likely to be in precarious work

Disabled people and people with health conditions often face multiple barriers to entering and remaining in employment. In NZ, the rate of employment for disabled people is 23% while the rate for non-disabled people is 70% (Health and Disability System Review, 2020). In Europe, people experiencing restrictions in their work life because of health conditions have an employment rate 30% less than people with no restrictions (Eurostat, 2015). For disabled people and people with health conditions who are participating in work, this work is more likely to be temporary or part-time, lower paying, and associated with fewer benefits than the work of people without disabilities (LaMontagne et al., 2016).

Entering or returning to work for disabled people and those with health conditions is an individual, complex, and multidimensional process.

There can be multiple barriers to employment for disabled people and people with health conditions including, individual, social, employment-specific, socio-economic, and environmental barriers. A more detailed discussion on employment, health and barriers can be found in Appendix Two.

Individual barriers

Individual barriers include, functional limitations preventing engagement in work that aligns with previous experience and/or skills, a lack of qualifications and stable work history, and confidence and self-esteem issues (MSD, 2019). An additional individual barrier is the reality of living with a long-term condition and the significant time and energy this requires, reducing energy available to engage in paid work (Fadyl et al., 2020a; Foitzek et al., 2018).

Social barriers

Disabled people and people with health conditions may experience stigma and discrimination from their community. Friends, family, and co-workers may question their capacity and competence to work.

Employment-specific barriers

Employers may hold biased views about disabled people and people with health conditions that influence their hiring decisions (Foitzek et al., 2018; MSD, 2019). Negative experiences can lead to people being fearful of having to disclose health information to prospective employers, contributing to a reluctance to engage with potential employment opportunities (Fadyl et al., 2020a). Other employment-related barriers in the NZ context include limited opportunities for a graduated return to work and limited availability of appropriate jobs.

Socio-economic and environmental barriers

Broader socio-economic and environmental barriers to work in NZ include abatement and other funding disincentives, resulting in a risk for disabled people and people with health conditions being worse off in employment. This has also been reported as a barrier to employment by international qualitative studies (Fadyl et al., 2020a).

In NZ and internationally, insufficient government funding to enable employers to provide people with health conditions an adequate level of support once they enter the workforce has been identified as another barrier (MSD, 2019).

Increased integration of employment support and healthcare services has been recommended to remove barriers

There is increasing evidence that addressing the employment needs of disabled people and people with health conditions should be considered a key component of integrated care delivery. Cross-agency and cross-sector partnerships may help to address the many barriers to employment experienced by disabled people and people with health conditions. Integrated programmes, that combine employment support with support from healthcare professionals, have been recommended to address the common objectives of these sectors (Priest & Lockett, 2020). However, it should be noted that it can be challenging to integrate services well.

Primary healthcare settings should be well placed to provide integrated employment and health services

It will be important to get the institutional and organisational requirements right to foster successful integration of services, however, the integration of employment support into primary care and community care settings could present an important opportunity to meet the employment needs of disabled people and people with health conditions. Many people with health conditions would like to work and see employment as a central part of their recovery (Saunders & Nedelec, 2014). However, periods of unemployment can lower confidence levels and self-esteem. Having a health professional to foster hope and expectations of a return to work may help to mitigate this, and GPs are well-placed to provide this type of support. Many people with long-term health conditions and/or disabilities have an established relationship with their GP and have a high degree of trust in their advice and guidance (Stewart, 2005).

The Oranga Mahi programme includes several new initiatives integrating employment support with primary healthcare

The cross-agency Oranga Mahi programme includes several initiatives that aim to provide integrated employment, welfare, and primary health support for people living with health conditions or disabilities. These initiatives are delivered in primary care settings, enabling GPs to facilitate access to a range of employment services for eligible patients. While the Oranga Mahi programme is made up of several different initiatives, including some designed for people with specific types of health conditions, all are under-pinned by a common theory of change. This theory proposes clients enrolled in the Oranga Mahi programme will experience improved wellbeing and employment outcomes if they:

- are assigned dedicated support from a team that works in an integrated way
- are supported to define their own wellbeing and employment goals and develop an individualised plan
- have access to health and social services that meet their needs.

Understanding the range of different integration models

Programmes that integrate employment support with primary healthcare services for disabled people and people with health conditions have been underpinned by a range of different integration models. There is significant overlap across the models with respect to integration activities. These models include patient navigation, case management/care coordination, co-location, adapted Individual Placement and Support (IPS), and multi-component approaches. Further discussion of how the models might potentially work better than separate provisions can be found in Appendix Three.

Patient navigation

Patient navigation approaches to care integration are designed to efficiently guide patients on their journey through the healthcare system. An important aspect of patient navigation is the integration of a navigator within a person's healthcare team who develop a one-on-one relationship with the individuals they are supporting, helping to set goals for recovery, developing an individualised action plan, and guiding them on their journey through the healthcare system (Peart et al., 2018).

Patient navigation is increasingly used in primary healthcare settings as primary care services begin to assume greater responsibility for coordinating care for patients and their families (Van Lerberghe, 2008).

Case management/care coordination

Case management as a strategy for improving health and social care integration aims to improve co-ordination of care to meet the holistic needs (physical, and psychosocial) of individuals. Programmes underpinned by a case management model of care integration involve a case manager working with a person to understand their health needs and to plan and coordinate appropriate care and are most commonly used to integrate services around the needs of individuals with long-term and/or complex health conditions (Ross et al., 2011). The reduction in the fragmentation of health and social care services is thought to result in better patient and service outcomes (Sadler et al., 2018).

Co-location

Co-location models of integration endeavour to bring together multiple services, that have traditionally been delivered separately, within a single community-based location (Memon & Kinder, 2017). Within primary care contexts, co-location typically involves the location of GPs and other health professionals in the same practice. The aim of this is to minimise fragmentation across the various health professionals involved in a person's care by providing people with a single point of access and ensuring they receive more responsive services (Ham, 2009).

Adapted Individual Placement and Support

The Individual Placement and Support (IPS) model was developed to support people with serious mental illness to return to or stay in competitive employment by integrating employment support with mental healthcare (Bond et al., 2020). Strong evidence for the effectiveness of traditional IPS services (Frederick & VanderWeele, 2019) has led to modifications that support the implementation of IPS among people with a wide range of health conditions and disabilities. A number of IPS modifications have been implemented in primary healthcare contexts (Whitworth, 2019).

Multi-component approaches

Multi-component approaches combine two or more interventions designed to integrate care. In practice, most interventions or programmes are underpinned by a multi-component approach (Guise et al., 2014). The different components of these approaches can be "fixed" where the components always occur together, or "variable" where implementations can involve only some components.

Findings

The literature search found no previous reviews focused on programmes integrating employment support with primary health or community care for disabled people and people with health conditions. However, the search found 21 evaluations of 17 unique international programmes, and 15 evaluations of 12 unique programmes delivered in NZ.

The largest international evidence base for programmes integrating employment support with primary care have been based on adaptations of IPS

Recently, IPS has been trialled in populations other than those with serious mental illness, including people with health conditions treated in primary care (Bond et al., 2019). Internationally, nine programmes have involved an adaptation of IPS delivered in a primary health setting. These programmes have been investigated among people with developmental disabilities, mild-to-moderate mental illness, PTSD, spinal cord injury, and general health and social problems. Three programmes adapting the IPS model for primary care populations have been evaluated in New Zealand.

The international evidence base for IPS employment support integrated within primary health settings has been growing rapidly. Several implementation studies have demonstrated the feasibility of adapting IPS for people with mental health or developmental difficulties who are being treated in primary or community care settings (McLaren et al., 2017; Noel et al., 2018; Ferguson et al., 2012).

Additionally, large studies adopting randomised controlled designs have shown programmes informed by IPS principles to be more effective at increasing work participation than traditional vocational rehabilitation, including for people with common mental health conditions (Overland et al., 2018; Reme et al., 2015), veterans with PTSD (Davis et al., 2012, 2018), veterans with spinal cord injury (Ottomanelli et al., 2012; Cotner et al., 2018), and young adults not in employment, education, or training (Sveinsdottir et al., 2020).

In Australia, IPS has been found to be suitable for delivery within Headspace centres, which serve as a one-stop-shops for young people who need help. An evaluation of IPS trialled across 13 Headspace sites found that 43% of young people who received IPS achieved an education and/or employment outcome (KPMG & DSS, 2019). However, a lower proportion of Aboriginal or Torres Strait Islander young people experienced either of these outcomes, suggesting that research is needed to develop culturally led and informed IPS programmes.

To date, only formative and process evaluations of IPS in New Zealand primary care settings have been conducted. The findings of these indicate that it is feasible to provide IPS services in general practices for people with mental health conditions. Following introduction of employment consultants in Wellington general practices, GPs reported that their patients were more confident and motivated to manage their health issues (Te Pou, 2013b). However, a lack of communication between GPs and Work and Income was identified, as well as differences in preferred eligibility criteria for the service.

A need to establish seamless referral systems between the health professionals and employment consultants, and a need for sustainable funding mechanisms, was identified

in a related evaluation of employment consultants integrated into Hamilton general practice teams (Te Pou, 2013a).

Take Charge, an IPS adaptation developed specifically for young benefit recipients with mild or moderate mental health problems and/or substance use issues, was highly valued by participants (Higgins et al., 2019; Wilson et al., 2019). Although engagement with the Take Charge coordinator and employment consultant was variable, participants reported that the programme respected their culture and increased their motivation to seek employment (Wilson et al., 2019).

A recent systematic review on support for gaining employment among people with long-term conditions found that IPS employment principles and practices address barriers to employment. Integration of employment specialists with treatment teams, personalised job searches, financial advice, and ongoing support once working were particularly important (Fadyl et al., 2020b).

Given the New Zealand evidence that IPS is feasible to implement in general practices, and the international evidence demonstrating that IPS adapted for primary health contexts can improve employment outcomes for people with a broad range of health conditions, more research investigating IPS in New Zealand primary care services is recommended. In particular, work is needed to understand how employment outcomes vary by ethnicity in response to IPS, and to ensure that programmes are designed and delivered in a way that supports the employment aspirations of Māori (Priest & Lockett, 2020).

Co-location of employment support within primary care settings has been found to reduce work absence internationally

While no New Zealand co-location programmes were identified in this review (except for IPS programmes), two international programmes were informed by a co-location model (Wynne-Jones et al., 2018; Sennehed et al., 2018). These both involved the integration of a vocational service delivered by a physiotherapist into primary care settings, as well as contact with employers to make workplace improvements. The programmes were evaluated using cluster randomised controlled designs and a range of positive work outcomes were identified.

In the United Kingdom, embedding a physiotherapist vocational advisor into general practices led to reduced work absence and produced significant cost savings for society compared to standard best care, resulting in a net societal benefit of £733 (Wynne-Jones et al., 2018).

In Sweden, work-focused physiotherapy care increased the odds of having work ability (defined as working at least four consecutive weeks) at one-year follow-up when compared to standard physiotherapy care (Sennehed et al., 2018). While these findings were demonstrated among people with musculoskeletal pain, they provide a rationale for developing and testing co-located vocational services with a broader range of patient groups in primary care, and in the New Zealand context.

Evaluations of case management programmes to integrate employment support and primary healthcare have produced mixed results

The review identified four international case management programmes and eight New Zealand case management programmes that had been evaluated.

No strong evidence for using case management to integrate employment and primary healthcare support was found from the international evaluations, which employed mixed methods and RCT designs. In the United Kingdom, variable or limited engagement from GPs and other health professionals made it difficult to compare case management with other types of support, although patients perceived that case management had supported RTW and management of health conditions (Department for Work and Pensions, 2015; Rannard et al., 2014). No strong support for intensive case management or coordination approaches was found in large evaluations in Switzerland or Denmark (Poulsen et al., 2014; Scholz et al., 2016).

Similarly, evaluations of New Zealand case management programmes have used a range of methods, and findings have varied (Bence-Wilkins & Conlon, 2018; CSRE, 2009; de Boer & Ku, 2017; Hall & Henshaw, 2018; Lunt, 2006; Moss et al., 2017). Findings revealed that limitations with communication and reporting systems made it difficult to share information and monitor programme outcomes over time.

Some outcome and impact evaluations demonstrated small benefits in response to case management, such as, an increase in part time work and staircasing onto additional support programmes (MSD, 2010), however, others reported non-significant findings (Cameron et al., 2019; MSD, 2018).

A strengths-based evaluation of Rākau Rangatira, a Kaupapa Māori programme, identified low enrolment but a high level of engagement from participants. Participants reported receiving support to manage mental health and substance use issues, as well as improvements in their physical health and wellbeing (FEM 2006 Ltd, 2018).

Patient navigation has received limited investigation, but findings are promising

The review identified one international patient navigation programme and one that had been delivered in the New Zealand context. Patient navigation involves the integration of a health navigator into a person's healthcare team. The navigator develops a one-on-one relationship with the individuals they are supporting, co-ordinating care, helping to set goals for recovery, and generally guiding them on their journey through the healthcare system.

An outcome evaluation of the Stay Well, Stay Working navigator programme in Minnesota indicated that the navigator model may increase engagement with health services over time, reduce physical limitations, and for those who are highly engaged, improve mental health and reduce need for social security benefits (Linkins et al., 2011).

Similarly, findings from a small implementation evaluation of the New Zealand programme Step Up suggest that the navigation model helped to increase awareness of entitlements and available services for people unable to work due to poor health (Malatest International, 2019).

Given the limited evidence, it is not possible to draw conclusions regarding the effectiveness of programmes that integrate employment support with primary healthcare using the patient navigation model. However, the positive findings from the identified evaluations suggest that further investigation is warranted.

Several programmes identified in this review included multiple components

Many of the programmes identified in this review could be described as multi-component initiatives. This is particularly true of the programmes classified according to the co-location and adapted IPS models of integration. In line with OECD recommendations, these programmes involved engagement with employers to identify appropriate work and make necessary workplace adaptations, in addition to the provision of support to manage health conditions.

Combining contact with employers and/or workplace modifications with health and social service coordination has been identified as a key feature of interventions that successfully help people with a chronic illness or disability into work (Pinto et al., 2018). Consistent with this, a population based RCT of a multi-component integrated care programme implemented in primary and secondary care settings in the Netherlands found that people with chronic low back pain receiving the programme returned to work significantly faster than people who received usual care (Lambeek et al., 2010). It should be noted that in NZ however, unlike in many European countries, there are few levers to require employer involvement in the return-to-work process.

Conclusions

This review has summarised published evaluations of programmes to integrate employment support and primary healthcare for disabled people and people with health conditions. It has enabled identification of the models used most frequently to develop these programmes, and programmes that may be worthy of investigation in the New Zealand context.

Overall, review findings suggest that multi-component programmes to integrate primary healthcare and employment support have the greatest likelihood of improving management of health conditions and helping people into sustainable employment. However, more investigation of these and other approaches is needed in the New Zealand context, and it is crucial to investigate more fully how these programmes work for Māori and Pacific Peoples.

Recommendations

Based on the evaluations reviewed, the following should be considered when designing and implementing programmes to integrate employment support with primary healthcare services for disabled people and people with health conditions in New Zealand:

- Multi-component programmes that involve employment specialists co-located within health services, such as IPS, have the strongest evidence base and the greatest likelihood of improving management of health conditions and helping people into sustainable employment. These programmes provide a comprehensive package of services and include engagement with prospective employers.

- More research investigating multi-component programmes, such as IPS, in New Zealand primary care services is recommended, particularly, work is needed to understand how employment outcomes vary by ethnicity in response to IPS, and to ensure that programmes are designed and delivered in a way that supports the employment aspirations of Māori.

- More investigation of other integration approaches is needed in the New Zealand context, to understand how they work for Māori and Pacific Peoples. It is essential to further investigate and identify how different integration approaches are experienced by Māori, and for Kaupapa Māori programmes to be developed.

- Successful programmes take a person-centred approach and are characterised by effective communication and coordination between health professionals, employment specialists, and employers.

- Programmes should recognise how health conditions and/or disabilities affect the capacity of people to engage with employment-focused activities, including when they have moved into work, and ensure that support for people to manage their health is available. Programmes that provide limited support from health professionals tend to have low levels of retention and engagement.

- Adequate communication and reporting systems are needed to ensure that programme delivery and outcomes can be consistently monitored over time. This data is critical for evaluating the success of a programme, and for informing any changes to design and implementation.

- It is important that programmes endeavour to achieve outcomes associated with sustainable employment, such as engagement in part-time work and health and wellbeing, rather than focusing solely on off-benefit employment outcomes.

- Outcomes need to be monitored over sufficiently long periods to detect clinically meaningful changes in outcomes over time.

Appendix One: Methodology

Evidence to inform the Oranga Mahi programme was needed within a specified timeframe so a rapid review was conducted. Rapid reviews provide high-quality evidence to support strategic decision making in a timely and cost-effective manner (Langlois et al., 2019). Several different approaches can be used to conduct a rapid review, therefore transparent reporting of methods is important to aid policymakers, practitioners, and researchers in the interpretation of review findings (Haby et al., 2016).

A rapid review of academic and grey literature was conducted to identify evaluations of programmes designed to integrate employment support with primary healthcare for disabled people and people with health conditions. Specific objectives of the review were to describe the range of models that have underpinned these programmes and summarise their outcomes. A narrative synthesis of the findings was completed to document the strength of the evidence for different types of programmes.

The literature search identified 15 evaluations of 12 unique programmes delivered in NZ, and 21 evaluations of 17 unique international programmes. The most frequently evaluated programmes in NZ were based on a case management model of integration, while most international programmes were based on an adaptation of the evidence-based model of Individual Placement and Support (IPS).

Search Strategy

MSD's Koha database, Google Scholar, and Google were used to identify scientific and grey literature pertaining to integrated health and employment supports delivered in primary or community care settings. The Canadian Best Practices Portal – Aboriginal Ways Tried and True was searched for literature on Indigenous programmes. To enhance the relevance of findings, each search was restricted to articles and reports published in English and to those published from 2010 onwards (except for searches to identify NZ evaluations, where no limit was placed on publication date). Searches were completed between January – March 2021. A combination of key words was used with Boolean logic and operators (i.e., 'and', 'or').

The following concepts and terms were used for the search:

> Review (review or meta-analysis or meta-analyses) AND Employment (employment or vocation or work or job) AND Service (service or intervention or support or approach or programme or program) AND Health Condition (health condition or illness or chronic illness or chronic condition or comorbid or mental health or mental illness or disability) AND Primary Care (primary care or primary health or primary medical or general practice or primary prevention or community care)

The rapid review was non-systematic in that the search was iterative and only immediately relevant search results were screened for inclusion. Reference lists of relevant publications were reviewed to identify any additional publications that may have been missed. Feedback from MSD's Research and Evaluation team informed searches for specific programmes of potential relevance within MSD's information repository.

Titles and abstracts of publications were screened to determine eligibility according to the inclusion/exclusion criteria described below.

Eligibility Criteria

Types of studies

The focus was on identifying reviews of the literature and meta-analyses in the first instance. Single studies and programme evaluations were also included if they had been missed by reviews. Priority was given to reviews and studies of individual or cluster randomised controlled trials (RCTs), quasi-randomised controlled trials, and controlled before and after studies. However, publications reporting other study designs (including qualitative and mixed methods designs) were considered if they described an evaluation of a relevant programme.

Programmes

Programmes, services, and/or interventions designed to integrate employment support with primary healthcare or community care were the focus of this review.

Target population

The population of interest included people with health conditions, including either physical or mental health conditions, and people with disabilities, including physical, sensory, and developmental disabilities.

Setting

Evaluations of programmes implemented within a primary or community care setting were included. Only programmes that had been delivered in OECD/high-income countries were considered, where healthcare settings and social support systems are likely to be most comparable to the New Zealand context.

Outcomes

No restrictions were placed on the type of outcomes investigated. These could include participant employment outcomes, quality of life, functioning, and physical and mental health indicators. Perceptions of programmes or services from the perspectives of key stakeholders (such as healthcare staff) were also considered, in addition to costs or benefits associated with the services.

Synthesis of Findings

Key information about the different programmes that have integrated employment support with primary health or community care for people living with health conditions and/or disabilities was organised into two tables. These tables presented information on models implemented in NZ and models implemented internationally, respectively. Information from the tables was then used to complete a narrative synthesis, summarising the outcomes associated with each programme.

Strengths and Limitations of the methodology

A rigorous approach was taken to this review by using a transparent, and reproducible search strategy to identify evaluations. Clear inclusion and exclusion criteria were also applied. Nevertheless, the search was not comprehensive. It is possible that other evaluations of relevant programmes have been conducted but were not identified by the search, particularly international evaluations published in the grey literature.

Many of the evaluations completed in New Zealand were identified through MSD's internal document management system. Furthermore, no quality assessment of the

included evaluations was completed. Because of this, the reliability and validity of the review findings is unclear and should be interpreted with caution.

Only one Kaupapa Māori integration programme (underpinned by a case management/coordination model) was identified in the literature search. However, there are a plethora of Māori non-government organisations and health providers that use integrated models of care. These were considered out of the scope of this review because the focus was on integration of employment support and primary healthcare services, but there are important opportunities to learn from evaluations of broader integration approaches.

Evaluations conducted to date have provided limited information on how programmes have been experienced by Indigenous people, including Māori. Of the 11 programmes identified as integrating employment support and primary healthcare services in New Zealand, only two (Rākau Rangatira and Take Charge) had evaluations reporting on what Māori thought of the programme. And except for Rākau Rangatira, none of the New Zealand evaluations endeavoured to collect outcomes that were of specific relevance to Māori.

Of the 17 international programmes, only one (IPS at Headspace) had an evaluation that reported on outcomes for young Indigenous people. None of the international evaluations reported that they had endeavoured to collect outcomes of value to Indigenous people, or that the cultural appropriateness of measures had been considered. Therefore, the present review cannot provide information on the success of these programmes for Māori, or for other Indigenous people.

Appendix Two: Employment, Health, and Barriers

This appendix contains more detailed information on the intersection of health and employment for disabled people and people with health conditions, including the various barriers they may experience in the employment domain.

Suitable paid employment has health benefits for disabled people and people with health conditions

There is strong evidence that participation in suitable paid employment is beneficial for health and wellbeing for several reasons (Waddell & Burton, 2006). In addition to work providing income necessary for engaging in society, work meets important psychosocial needs, often serving as a source of individual identity, meaning, and social status (Waddell & Burton, 2006). That said, some physical and psychosocial aspects of work can also pose risks to health (Waddell & Burton, 2006).

The health promoting effects of work have been well-documented among disabled people and people with health conditions (Leonardi & Scaratti, 2018). Remaining in or re-entering the workforce is associated with better health outcomes, reduced risk of long-term incapacity, increased independence, and improved quality of life and wellbeing (Waddell & Burton, 2006). People with disabling conditions also report that work generates feelings of normality and provides opportunities for socialisation (Saunders & Nedelec, 2014). There is clear evidence that not being employed is detrimental to health and wellbeing.

Disabled people and people with health conditions have lower rates of employment and are more likely to be in precarious work

There are a range of health and wellbeing benefits associated with participation in work, however, disabled people and people with health conditions often face multiple barriers to entering and remaining in employment. In NZ, the rate of employment for disabled people is 23% while the rate for non-disabled people is 70% (Health and Disability System Review, 2020). In Europe, people experiencing restrictions in their work life because of health conditions have an employment rate 30% less than people with no restrictions (Eurostat, 2015). Studies in the United Kingdom and United States have found labour force participation rates for people with disability to be less than half those of people without disability (Hogan et al., 2012).

For disabled people and people with health conditions who are participating in work, this work is more likely to be temporary or part-time, lower paying, and associated with fewer benefits than the work of people without disabilities (LaMontagne et al., 2016). Some disabled people and people with health conditions are more at risk of poorer outcomes. These include those whose work capacity is severely impacted; those with mental health conditions; older workers; those with low qualifications or skills that are less in demand; and those who have left work as opposed to those who are still attached to employment (REF).

Difficulties engaging in stable and secure work are likely to be experienced by an increasing number of people over time. Factors such as, aging populations, increases in chronic health conditions, and poverty, among other causes, mean the prevalence of

people living with health conditions is increasing globally, in addition to the proportion of people managing multiple health conditions (Esteban et al., 2018).

Similar barriers to employment have been identified in New Zealand and internationally

In NZ, key barriers that stop people getting into work were identified by MSD engaging with a broad range of stakeholders between November 2012 and February 2013. Stakeholders included people with disabilities and/or health conditions, providers, advocates, individuals working in the disability sector, employers, and Work and Income staff (MSD, 2019). Consultation occurred through four online surveys, three public meetings in Auckland, Wellington, and Christchurch, and six single sector workshops. Online feedback was received from 807 people and public meetings and workshops were attended by over 250 people.

Barriers have also been described in recent international reviews and surveys investigating the experiences of people with long-term health conditions and/or disabilities seeking paid employment (Fadyl et al., 2020a; Vornholt et al., 2018). For example, a qualitative systematic review and thematic synthesis of 62 studies described the social, cultural and biographical factors affecting opportunities for paid work among people living with long-term health conditions from 15 different countries (Fadyl et al., 2020a). An online survey administered in seven European countries has also explored factors having a negative impact on the work lives of 487 participants with six different types of chronic health conditions (Foitzek et al., 2018).

Disabled people and people with health conditions experience multiple barriers to employment

Entering or returning to work for disabled people and those with health conditions is an individual, complex, and multidimensional process. Similar barriers to engaging in employment have been identified by disabled people and people with health conditions across countries. These include individual barriers, social barriers, employment-specific barriers, and socio-economic, and environmental barriers.

Individual barriers

Individual barriers reported by stakeholders in NZ include functional limitations preventing engagement in work that aligns with previous experience and/or skills, a lack of qualifications and stable work history, and confidence and self-esteem issues (MSD, 2019). Stakeholders reported that limited work experience contributes to reduced confidence, reduced hope for employment, and a fear of the unknown. Internationally, evidence suggests that an additional individual barrier is the reality of living with a long-term condition and the significant time and energy this requires, reducing energy available to engage in paid work (Fadyl et al., 2020a; Foitzek et al., 2018).

Social barriers

A social barrier to employment identified by people in NZ is negative assumptions held by others in the community. Friends and family members, as well as co-workers may question the capacity and competence of disabled people and people with health conditions to work (MSD, 2019). Stigma and discrimination towards those with health conditions have also been reported internationally (Foitzek et al., 2018; Vornholt et al., 2018). In NZ and internationally, an absence of appropriate role models, or examples of

disabled people and people with health conditions engaged in the workforce, is an additional social barrier to work (Fadyl et al., 2020a; MSD, 2019).

Employment- specific barriers

In NZ and internationally, attitudes of employers are an employment-specific barrier to work. Some employers hold biased views about disabled people and people with health conditions that influence their hiring decisions (Foitzek et al., 2018; MSD, 2019). Experiences of negative attitudes from past employers can lead to people being fearful of having to disclose health information to prospective employers, contributing to a reluctance to engage with potential employment opportunities (Fadyl et al., 2020a).

Other employment-related barriers in the NZ context include limited opportunities for a graduated return to work and limited availability of appropriate jobs. Research in a number of countries has noted that specific job requirements, such as having a high workload or many responsibilities, can result in pressure and stress for disabled people and people with health conditions, who are often required to perform their job in the same amount of time as those without any conditions (Foitzek et al., 2018; Vornholt et al., 2018). Limited accessibility of workplaces has also been identified as a central concern of people with long-term conditions seeking work (Fadyl et al., 2020a).

Socio-economic and environmental barriers

Broader socio-economic and environmental barriers to work identified in NZ include abatement and other funding disincentives, resulting in a risk for disabled people and people with health conditions being worse off in employment. Fear of losing benefits, particularly medical benefits that people cannot afford to lose, has also been reported as a barrier to employment by international qualitative studies (Fadyl et al., 2020a). Changes to benefits as a result of engaging in employment, especially employment that is part-time or precarious, has been found to decrease financial security for people with health conditions (Fadyl et al., 2020a).

In NZ and internationally, insufficient government funding to enable employers to provide people with health conditions an adequate level of support once they enter the workforce has been identified (MSD, 2019). Furthermore, while New Zealand employers are required to take reasonable measures to meet an employee’s needs, international jurisdictions have placed greater obligations on employers to support work retention and return to work for disabled people and people with health conditions (MBIE, 2022).

An additional socio-economic and environmental barrier to employment is poverty. Several studies have demonstrated that poverty prevents access to the resources needed to get to or present appropriately at work (Fadyl et al., 2020a).

Appendix Three: Understanding Integrated Employment Support Models

This appendix details the case for integrated employment support programmes. It discusses the various structures and systems that support successful integration and describes the different integration models in greater depth.

Increased integration of employment support and healthcare services has been recommended to remove barriers

Cross-agency and cross-sector partnerships may help to address the many barriers to employment experienced by disabled people and people with health conditions. Both health and employment sectors are recognising the importance of ensuring employment support is available for people who are unemployed, and of interventions to improve and foster the health of the working-age population. Integrated programmes, that combine employment support with support from healthcare professionals, have been recommended to address the common objectives of these sectors (Priest & Lockett, 2020).

The integration of employment support with healthcare provision builds on a more general trend in healthcare to deliver integrated care (Singer et al., 2020). While there is significant variation in the conceptualisation of integrated care, this type of care delivery is characterised by consistent coordination within and across healthcare teams, is continuous over time, is person-centred, and emphasises the central role of service users in making decisions about their care (Singer et al., 2011).

The provision of successfully integrated person-centred care has been promoted to improve the availability, quality, and efficiency of services, particularly for people with complex health needs (Valentijn et al., 2013). Evaluations indicate that initiatives to integrate care in health contexts have resulted in improved perceptions of quality of care, increased patient satisfaction, and improved access to care (Baxter et al., 2018), as well as reduced health service costs (Rocks et al., 2020).

However, it should be noted that it can be challenging to integrate services well. At the organisational level, for an integrated approach to be successful it is likely to require, for example, the need to lead a diverse team of practitioners (sometimes virtually), building and sustaining a collaborative culture, developing and managing systems and structures to support integration, and fostering inter-agency and inter-sectoral collaboration (Te Pou, 2020).

There is increasing evidence that addressing the employment needs of disabled people and people with health conditions should be considered a key component of integrated care delivery. For people with serious mental health conditions, the integration of employment support with clinical treatment has been found to increase clinicians' awareness of the benefits of employment for health and wellbeing, facilitate early referral to employment services, encourage joint planning from employment and health agencies, and support more people into work than non-integrated employment support services or standard psychiatric care (Modini et al., 2016).

While less research has investigated the integration of employment support with healthcare for people with physical health conditions and other disabilities, available

findings indicate that combining work-focused strategies with clinical care is more effective than using either strategy alone (Butler et al., 2012).

Primary healthcare settings should be well placed to provide integrated employment and health services

Within health systems, primary healthcare settings deliver services to prevent, diagnose, educate, and provide care. They also serve as a gateway to other specialist services that a person may need (Health and Disability System Review, 2020, p104). Primary healthcare settings are increasingly serving as 'hubs' of care coordination, where multiple health professionals (e.g. general practitioners (GPs), nurses, pharmacists, physiotherapists) work together to meet the health and social needs of people seeking care (Valaitis et al., 2017).

It will be important to get the institutional and organisational requirements right to foster successful integration of services, however, the integration of employment support into primary care and community care settings could present an important opportunity to meet the employment needs of disabled people and people with health conditions. Many people with health conditions would like to work and see employment as a central part of their recovery (Saunders & Nedelec, 2014). However, periods of unemployment can lower confidence levels and self-esteem. Having a health professional to foster hope and expectations of a return to work may help to mitigate this, and GPs are well-placed to provide this type of support. Many people with long-term health conditions and/or disabilities have an established relationship with their GP and have a high degree of trust in their advice and guidance (Stewart, 2005).

GPs are often the first point of contact for people when health problems arise. Therefore they are well-placed to pick up problems at the earliest possible time, to ask about employment status, and to offer the necessary treatment to prevent some problems becoming more severe (Te Pou, 2013a). Research focused on people with mild mental health conditions has found that these individuals begin to consult their GP more frequently in the two to three years before they begin claiming health or disability benefits (Whittaker et al., 2010). Therefore, there is an important window of opportunity for GPs to identify frequent users who would benefit from occupational support, helping them to remain in work.

The 2011 Australian and New Zealand Consensus Statement on the Health Benefits of Work noted that medical, nursing, and allied health professionals all have a role to play in promoting the health benefits of work and in offering support and encouragement to those attempting to enter the workforce (Australasian Faculty of Occupational and Environmental Medicine, 2011). However, there is potential to increase the opportunities for GPs in NZ to do this. Currently, employment support from GPs is largely focused on the provision of work capacity medical certificates, and there is an absence of employment services to directly refer patients to (Te Pou, 2013a).

Earlier explorations of integrated employment and primary health services in NZ, such as the Providing Access to Health Solutions (PATHS) initiative, suggest that GP care coordinated with specialised employment support and dedicated Work and Income assistance has potential to improve the confidence of people to manage their health (Te Pou, 2013b), and increase engagement in paid employment (Centre for Social Research and Evaluation, CSRE, 2009).

The Oranga Mahi programme includes several new initiatives integrating employment support with primary healthcare

The cross-agency Oranga Mahi programme includes several initiatives that aim to provide integrated employment, welfare, and primary health support for people living with health conditions or disabilities. These initiatives are delivered in primary care settings, enabling GPs to facilitate access to a range of employment services for eligible patients. While the Oranga Mahi programme is made up of several different initiatives, including some designed for people with specific types of health conditions, all are under-pinned by a common theory of change. This theory proposes clients enrolled in the Oranga Mahi programme will experience improved wellbeing and employment outcomes if they:

- are assigned dedicated support from a team that works in an integrated way
- are supported to define their own wellbeing and employment goals and develop an individualised plan
- have access to health and social services that meet their needs.

National and international reports indicate a need for the Oranga Mahi programme

Several recent reports have highlighted the potential benefit of improving access to health and employment supports, as intended by the Oranga Mahi programme. For example, the 2019 Welfare Expert Advisory Group (WEAG) report Whakamana Tāngata noted that improving access to health services for people in receipt of a benefit is necessary to ensure they can maintain and improve their physical and mental wellbeing, and that this is particularly important for disabled people and people with health conditions (Welfare Expert Advisory Group, 2019).

The 2018 Organisation for Economic Co-operation and Development (OECD) report on mental health and work in NZ outlined the high prevalence of mental health conditions in NZ and recommended that evidence-based employment services be integrated with mental health treatment (OECD, 2018). The OECD also recommended shifting spending from specialist to primary care, strengthening the employment competence of the health sector, and providing integrated health and employment services to people claiming welfare benefits, irrespective of benefit type (OECD, 2018).

Understanding the range of different integration models

The initiatives currently being implemented as part of the Oranga Mahi programme can be contextualised alongside other programmes that have integrated employment support with primary healthcare, both in NZ and internationally.

Programmes that integrate employment support with primary healthcare services for disabled people and people with health conditions have been underpinned by a range of different integration models. These models include patient navigation, case management/care coordination, co-location, adapted Individual Placement and Support (IPS), and multi-component approaches. There is significant overlap across the models with respect to integration activities.

Patient navigation

Patient navigation approaches to care integration are designed to efficiently guide patients on their journey through the healthcare system. Harold Freeman, an American oncologist, is widely regarded as the founder of the patient navigation model (Freeman, 2006). Freeman introduced the Harlem Patient Navigation Program in 1990 while serving as the Director of Surgery at Harlem Hospital. This aimed to reduce disparities in breast cancer care by introducing patient navigators to facilitate timely access to diagnosis and treatment (Freeman & Rodriguez, 2011).

Over the past 30 years, the scope of patient navigation has expanded to address barriers to care for a broad range of health issues, across diverse contexts (Valaitis et al., 2017). Patient navigation is increasingly used in primary healthcare settings as primary care services begin to assume greater responsibility for coordinating care for patients and their families (Van Lerberghe, 2008).

An important aspect of patient navigation is the integration of a navigator within a person's healthcare team, helping to overcome the delivery of fragmented care that is frequently experienced by people with long-term health conditions. Navigators develop a one-on-one relationship with the individuals they are supporting, helping to set goals for recovery, developing an individualised action plan, and guiding them on their journey through the healthcare system (Peart et al., 2018).

Case management/care coordination

Case management as a strategy for improving health and social care integration aims to improve co-ordination of care to meet the holistic needs (physical, and psychosocial) of individuals. The reduction in the fragmentation of health and social care services is thought to result in better patient and service outcomes (Sadler et al., 2018).

Programmes underpinned by a case management model of care integration involve a case manager working with a person to understand their health needs and to plan and coordinate appropriate care. Case management (also known as care coordination) is a model of integration that was first developed in the 1960s, in response to the de-institutionalisation of large numbers of people with mental health conditions (Lukersmith et al., 2016).

Since the 1990s, case management has been used with diverse populations in a broad range of healthcare settings, including hospital, rehabilitation, long-term care, and community-based settings (Lukersmith et al., 2016). The widespread implementation of case management has led to highly variable descriptions of the approach. This has resulted in some uncertainty about what exactly case management involves (Ross et al., 2011).

Case management is most commonly used to integrate services around the needs of individuals with long-term and/or complex health conditions (Ross et al., 2011). Within primary heath and community care settings, case managers are typically nurses or social workers. Their key tasks include case finding (to identify individuals most in need of enhanced care integration), assessment of individual needs, development of an individualised care plan, care coordination, and regular review, monitoring, and adjustment of the care plan (Goodman et al., 2010).

Several factors that are important to the success of case management initiatives have been identified. These include: targeting of support to people with a high level of need; clarity about the case manager role and support to ensure case managers have the right

competencies; appropriate caseloads; and the involvement of multiple healthcare professionals in the development of care plans (Hudon et al., 2017; Ross et al., 2011).

Co-location

Co-location models of integration endeavour to bring together multiple services, that have traditionally been delivered separately, within a single community-based location (Memon & Kinder, 2017). Co-location gained attention as an integration approach following the creation of care trusts in the United Kingdom in the early 2000s. These trusts combine responsibilities for commissioning and providing health and social care under a single statutory body (Ham, 2009).

Across countries there is significant variation in the level of attention that national policies give to co-location as a method for improving integration in primary care (Bonciani et al., 2018). Within primary care contexts, co-location typically involves the location of GPs and other health professionals in the same practice. The aim of this is to minimise fragmentation across the various health professionals involved in a person's care by providing people with a single point of access and ensuring they receive more responsive services (Ham, 2009).

In addition to promoting cost reductions, better resource utilisation, and more efficient services, co-location is proposed to facilitate multi-professional teamwork, opportunities to share information, and chances to learn from one another (Memon & Kinder, 2017).

Adapted Individual Placement and Support

Individual Placement and Support (IPS) is a model that was developed to support people with serious mental illness to return to or stay in competitive employment by integrating employment support with mental healthcare (Bond et al., 2020). The model has a set of widely agreed upon principles and practices, and a validated fidelity scale has been developed to monitor adherence to these practices (Kim et al., 2015). In high fidelity implementations, employment specialists are co-located within secondary mental health service settings, providing individuals with one-on-one assistance to find and maintain employment. Each employment specialist is responsible for 20 or fewer active clients at any given time to ensure that sufficiently intensive support can be provided (Becker et al., 2011).

Strong evidence for the effectiveness of traditional IPS services (Frederick & VanderWeele, 2019) has led to modifications that support the implementation of IPS among people with a wide range of health conditions and disabilities. A number of modifications have been implemented in primary healthcare contexts (Whitworth, 2019).

Multi-component approaches

Multi-component approaches combine two or more interventions designed to integrate care. In practice, most interventions or programmes are underpinned by a multi-component approach (Guise et al., 2014). The different components of these approaches can be "fixed" where the components always occur together, or "variable" where implementations can involve only some components. The Adult Improving Access to Psychological Therapies programme (IAPT) in the UK is an example of this approach. It is characterised by three factors: the use of evidenced-based psychological therapies; routine outcome monitoring; and, regular and outcomes focused supervision for practitioners (NHS,2018).

Multi-component approaches that focus on incorporating employment support into health settings provide a package of services, including access to advice from an expert (e.g. a case manager), a rapid and competitive job search, ongoing feedback and support, networking with employers, education and training, and peer mentor support (Pinto et al., 2018). A difficulty with evaluating multi-component approaches is identifying which specific interventions produce the most consistent benefits for which groups.

Appendix Four: Table of services included in this literature review

Integrated primary health and employment services table

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